2008-1

Medical Supervision Plan

Bannock County Ambulance District
Chubbuck Fire Department
Fort Hall Fire and EMS
Inkom Fire Department
Bannock County Search and Rescue
Simplot SERV-1

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System Design

Our “EMS System” is comprised of multiple agencies, all with multiple individuals with varying roles, experience, operational responsibilities and Credential levels. This includes a diverse group of healthcare professionals including Communications, First Responders and Transport Providers. Together, this “System” provides the basis for seamless delivery of care to acutely ill or injured patients in our community. Remember that acutely ill or injured patients really don’t care which agency comes to their aid. What they do care about is that whoever does provide their care knows what they’re doing and takes care of them in a timely and compassionate way. Put in a different way, the sum of our collective efforts is far more powerful than our individual capabilities.

In practical terms, imagine the impact on cardiac arrest patient outcome if we didn’t send the closest First Responder with an AED. Imagine the impact on a seriously injured patient if their travel to the Trauma Center from the remote areas of the County had to routinely occur by ground (no LifeFlight). Imagine the impact on the progressively worsening anaphylaxis patient if we had no ALS capabilities. Imagine how tragic it would be if we didn’t provide pre-arrival CPR instruction that could literally save the life of a child that fell in a pool before a First Responder arrives on-scene. Our collaborative approach maximizes the potential outcome of the patients we are entrusted to serve.

Fortunately, we have a System that maximizes the opportunity to deliver appropriate care to our patients as defined by a unified set of EMS Treatment Guidelines. The more consistent we are with the care we provide, the better our care is.

System minimum requirements are the following:

- Tiered response may be utilized based upon criteria determined by specified Medical Priority Dispatch (MPD)
- Paramedic ambulances must have a minimum of one paramedic
- ILS ambulances must have a minimum of one Advanced EMT
- BLS ambulances must have a minimum of one EMT-Basic

Appropriate level of response will be determined by MPD and response will be consistent with level of agency licensure within the system. If agency is licensed at ALS level, then deployment plans should ensure availability of ALS response for all ALS cases.

Role of the System Medical Director

EMS personnel provide medical care under the direction of the system medical director. The medical director is responsible for development of the medical supervision plan, treatment guidelines, provider credentialing, and quality assurance. The medical director's authority and responsibilities will be consistent with IDAPA 16.02.02 Idaho Code "Rules of the Idaho EMS Physician Commission". System Medical Director will have a field presence and respond to calls to provide direct medical direction and observe personnel performance.

Guideline Accordance

All medical care within the EMS System should be provided according to the current Portneuf Medical Center Clinical Guidelines. These guidelines will be reviewed and updated at least every 2 years. Changes to guidelines or information of importance between updates will be disseminated using Medical Directives.

Each agency must have access to On-Line Medical Control (OLMC). This can either be accomplished via radio or cell phone. OLMC must be from a physician unless a physician extender (PA, NP) is the highest level of provider at the receiving facility. OLMC is available from the Emergency Department at Portneuf Medical Center.

All individuals providing medical care as part of the EMS System will be Credentialed according to the Credentialing requirements of the EMS System. Specific medical care in the system will be delivered by appropriately Credentialed AND (if applicable) Qualified individuals within the environment specified in the Clinical Guidelines.

Individuals holding current Qualifications may deliver specialty care as defined by the SOPs and Clinical Guidelines when appropriate equipment and conditions exist (Qualifications follow the individual).

All individuals providing medical care as part of the EMS System will be currently certified by the Idaho EMS Bureau.

All organizations providing medical care as part of the EMS System will comply with Idaho EMS Bureau requirements for Agency Licensure and Provider Certification.

All 9-1-1 requests for care will be managed by Communications according to the requirements of the currently adopted Medical Priority Dispatch System. This includes call triage, pre-arrival instructions, post dispatch instructions and response determinants.

First Response ILS and/or ALS level of care is supplemental to the System minimum requirements.

Standby and on-site Special Event Providers Minimal Equipment will be determined based on the need of the specific event.

During unusual or extreme conditions or circumstances, the above criteria may be modified to best meet the needs of the EMS System.

As this document is utilized by several agencies, the use of all modalities, interventions and drugs may not be applicable and are dependent upon each agency's scope of service.

Credentials

Every Provider that delivers medical care within the System must be "Credentialed to Practice" in addition to holding a current State of Idaho Certification. The goal is to ensure continuous competency of certified EMS personnel.

Credentials

All Credentialed Providers within the EMS System are allowed to provide care under the direction of the Medical Director. Credentialing is the final approval of the Medical Director that ensures an individual's competency to care for patients as part of the Emergency Medical Services System. An individual is "Credentialed to Practice" when he or she successfully meets and maintains the defined Credentialing requirements. The levels of Credentialing are:

- Emergency Medical Responder (EMR)
- Emergency Medical Technician – Basic (EMT-B)
- Advanced Emergency Medical Technician – Ambulance (AEMT-A)
- Emergency Medical Technician – Paramedic (EMT-P)

Every Provider that delivers medical care within the System must be initially Credentialed (for example when the provider is new to the System or just received a new State Certification) and must maintain his Credentials in order to continue providing care at a designated level.

Qualifications

Qualifications are added competencies in specialty areas such as Training, USAR, Hazardous Materials Medicine, Tactical Medicine, etc. The Qualifications

available may change based on the needs of the EMS System. The requirements for all Qualifications are in addition to Credentialing requirements.

Certified EMS Personnel Credentialing

In order for a EMS provider to be recognized and allowed to perform within the t EMS System, he/she must initially complete the following:

First Responder/EMR:

- Certification at First Responder/EMR level or above by Idaho EMS Bureau
- Agency Orientation
- CPR
- Skills verification

Maintenance of credentials:

- Continuous Certification
- Good standing with agency
- Participation in agency in-services
- Annual skills review

Emergency Medical Technician - Basic

- Certification at EMT-Basic level or above by Idaho EMS Bureau
- Agency Orientation
- CPR
- Skills verification
- Completion of Field Training Program

Maintenance of credentials:

- Continuous Certification
- Good standing with agency
- Participation in agency in-services
- Annual skills review

Advance Emergency Medical Technician - Ambulance

- Certification at Advanced EMT –A level or above by Idaho EMS Bureau
- Agency Orientation
- CPR
- Skills Verification
- Completion of Field Training Program

Maintenance of credentials:

- Continuous Certification
- Good Standing with Agency
- Annual Skills Review
- Participation and Compliance with Agency QA Program

Emergency Medical Technician - Paramedic

- Certification at Paramedic level by Idaho EMS Bureau
- Agency Orientation
- CPR
- ACLS
- PALS
- Completion of Field Training Program
- Skills verification

Maintenance of credentialing:

- Continuous certification
- Good Standing with Agency
- ACLS
- PALS
- Annual Skills Verification
- Participation and compliance with agency QA program

Suspension or Revocation of Credentials

It is important for the individuals and agencies that are part of the EMS System to always focus on providing clinical care that is appropriate for the patients we serve. We will always be accountable for our actions and we will focus on a non-disciplinary approach to support and re-educate providers in the System. On occasion, circumstances arise that may lead to a change in Credential status, such as suspension or revocation.

As in any practice of medicine, there are actions that are deemed unacceptable for any Provider involved in medical care of the patients. In the EMS Systemt, these actions are known as the *Five Deadly Sin*s. If substantiated through a process of appropriate investigation and peer review, any Provider found to be involved in any of these actions will be Decredentialed in the System. These actions are:

- Falsification of a patient care document
- Intentionally withholding care from a patient
- Intentionally harming a patient

- Providing care while impaired by alcohol or drugs
- Failure to remediate and/or participate in required education and/or review

Additionally, a provider may be credentialed at a lower provider level than his current state certification.

Under state rule, any change in credential status will be reported to the Idaho EMS Bureau.

Skills/Interventions Authorized by Credential Level

Each Credential level builds on all previous Credential levels. The following skills/interventions are authorized by Credential Level in our System:

Emergency Medical Responder (EMR) Credentials

- Patient assessment
- Spinal movement restriction
- CPR/AED application
- Oropharyngeal airway
- Oropharyngeal suctioning
- Nasopharyngeal airway
- Oxygen administration
- Bag-Valve-Mask device
- Bandaging/splinting
- Emergency childbirth
- Epinephrine Autoinjector – if participating agency

Emergency Medical Technician- Basic (EMT-B) Credentials

All EMR skills/interventions plus:

- Medication administration: Assist with patient prescribed nitroglycerin, epipen and inhaled beta agonist, glucagon. Epipen if participating agency
- Glucometry
- Pulse-Oximetry
- 12-lead EKG Acquisition

Advanced Emergency Medical Technician- Ambulance (AEMT-A) Credentials

All EMR and EMT-B skills/interventions plus:

- Medication administration: all medications and routes as outlined in EMT-B and AEMT-A level Patient Care Guidelines
- Peripheral intravenous access
- Intraosseous access
- Supraglottic (Combitube/King) airway insertion
- Orotracheal intubation
- Gastric tube insertion
- Tracheal suctioning
- End-tidal C02 assessment

Emergency Medical Technician- Paramedic (EMT-P) Credentials

All EMR, EMT-B, and AEMT-A skills/interventions plus:

- Medication administration: all medications and routes as outlined in EMR, EMT-B, AEMT-A, and EMT-P level Patient Care Guidelines
- Needle cricothyrotomy
- Surgical cricothyrotomy
- Pleural decompression
- External jugular vein cannulation
- Three and twelve Lead ECG acquisition and interpretation
- Manual cardioversion/defibrillation/pacing
- Death Pronouncements

Skills Verification

As part of initial and ongoing credentialing, the following skills will be reviewed on at least an annual basis.

Skills will be picked randomly to include to following:

1. Skills to be tested at EMR/EMT-Basic level:
    - Four (4) random skills to be chosen from the National Registry skills test:
        a. Upper airway adjuncts and suction
        b. Bag-valve mask
        c. Bleeding control/shock management
        d. AED
        e. Immobilization—joint
        f. Immobilization—long bone
        g. Immobilization--traction
        h. Oxygen administration
        i. Patient assessment—medical
        j. Patient assessment—trauma

k. Spinal immobilization—seated
l. Spinal immobilization--supine

- For EMT-B, Four (4) random skills to be chosen from the System skills test:
  a. Monitor Set-up
  b. Radio, telephone, and patient transfer report
  c. IV set-up
  d. Ambulance compartment and jump bag inventory
  e. Radio procedures
  f. Run reports
  g. GPS, Air ambulance dispatch, and landing zone
  h. Mapping
  i. Glucometry

2. Skills to be tested at EMT-Advanced level:
   - Two (2) mandatory skills from the National Registry skills test:
     a. Endotracheal intubation for the adult and pediatric patient
     b. IV therapy
   - Two (2) random skills from the National Registry skills test:
     a. As listed under EMT-Basic above.
   - Four (4) random skills from the System skills test:
     a. As listed under EMT-Basic above.
3. Skills to be tested at EMT-Paramedic level:
   - Complete an Ultra-code test for the adult and pediatric patient.
   - The Ultra-code will be scenario based and all skills and interventions must be accomplished, on the manikin, to national standards.
   - Scenarios can be based on either the pre-hospital setting or the interfacility transport setting.
   - Skills and medications that are used infrequently will be tested during these scenarios to ensure consistent proficiency levels for those areas.
   - Each Ultra-code will contain four (4) scenario progressions

Intubation within the system will follow the intubation standard as established by the EMSPC.

Supraglottic airways are the standard airway for Advanced EMTs within the system. Advanced EMTs wishing to perform endotracheal intubation must meet the same requirement as paramedics and participate in intubation skills review.

Agency Orientation

Each agency will implement an orientation program for all new providers. This orientation program will familiarize the new provider with specifics of the agency and the system. The orientation program will include but not limited to the following:

- Credentialing process, including field training program
- Equipment and vehicles
- Communication procedures
    - Dispatch and OLMC
    - Phone and radio
- Treatment Guidelines
- Destination guidelines
- Infection Control
- Incident Reporting
- Medical Supervision Plan
- Safety and uniforms
- Air Medical Utilization and Landing Zone
- Extrication Awareness
- Continuing Education

Patient Care Reporting Requirements

Guiding Principles of Documentation

At a minimum, all patient care documentation by any Credentialed Provider in the System shall:

- Be truthful, accurate, objective, pertinent, legible, and complete with appropriate spelling, abbreviations and grammar.
- Reflect our patient's chief complaint and a complete history or sequence of events that led to their current request or need for care.
- Detail our assessment of the nature of the patient's complaints and the rationale for that assessment.
- Reflect our initial physical findings, a complete set of initial vital signs, all details of abnormal findings considered important to an accurate assessment and significant changes important to patient care.
- Reflect our ongoing monitoring of abnormal findings.
- Summarize all assessments, interventions and the results of the interventions with appropriate detail so that the reader may fully understand and recreate the events.
- Include an explanation for why an intuitively indicated and appropriate assessment, intervention, or that is part of our Clinical Operating Guidelines did NOT occur.
- Clearly describe the circumstances and findings associated with any complex call or out-of-the-ordinary situations.
- Be available in an acceptable time period after our patient encounter.

- Remain confidential and be shared only with legally acceptable entities.

Minimal Data Elements Required for Patient Care Report Documentation including First Responder Agencies

The minimum data to be collected on all patient encounters.

- Date and time of incident
- Location of incident
- Responders and incident number
- Patient name (John Doe/Jane Doe if unknown)
- Gender
- Chief complaint
- Patient assessment
- Available witness account of incident
- Patient treatment provided
- Transporting unit and location of transport
- Refusal of treatment

Agencies are strongly encouraged to utilize the Idaho PERCS for documentation purposes. This allows standardized reporting within the system. It also allows for immediate chart review for QA purposes.

Clinical Errors and Reporting

As much as we don't like it, in any practice of medicine, it is understood that errors will occasionally occur. In order to improve as a System, be a responsible member of the medical community, and be accountable to the citizens we serve, it is essential that these incidents be promptly and thoroughly reviewed. The purpose of the review is to attempt to determine why the error occurred and address those things that we can change as a System to prevent further similar errors from occurring.
As a Credentialed Provider, and as part of that privilege to participate in care within the System, all Providers agree to report clinical errors through the appropriate organizational channels.
All Providers involved in reviewing errors and evaluating care are committed to an educational (non-punitive) approach to correcting circumstances that led to a medical error.

Clinical Review Process

The Clinical Review Process is designed to investigate all questions regarding clinical care issues. The process assures that the EMS Medical Director is aware of and can act on current issues as they arise in order to provide timely feedback, education and track clinical performance.

System Impact

All system Credentialed Providers are expected, as part of their privilege to practice within the EMS System, to actively support and participate in the Clinical Review Process. All agency employment contracts should state compliance with the system clinical review process.

Philosophy

The goal of the EMS System Clinical Review Process is to protect the public that we serve by assuring appropriate medical care. We recognize that in any practice of medicine performed by humans, errors will occasionally occur. We are committed to looking at all clinical issues as a system and require that anyone engaging in medical care participate in the Clinical Review Process. The process is structured to be fair and objective with an emphasis on education as the means to improve personal and collective performance. Our collective desire is to foster an environment where the self reporting of medical concerns and incidents is not only encouraged but expected.

Steps in the Clinical Review Process

Contact with the Agency EMS Officer/Coordinator and Medical Director

This is the first step in the process. Circumstances that should be reported to the Agency EMS Officer/Coordinator and Medical Drirector will include the following:

- Those that could potentially have an adverse impact on patient care, or on the System as a whole (any medical error, regardless of severity)
- A Provider operating outside the scope of their Credentials or qualifications.
- A Provider failing to initiate care appropriate to the patient condition and their level of Credentialing.
- A Provider delivering patient care while impaired by the use of drugs or alcohol.
- A Provider providing patient care that is in conflict with the System Clinical Guidelines.
- A Provider refusing to accompany a patient to the hospital, if so requested, and is reasonably able to comply with the request.
- Needle and/or surgical cricothyrotomy are attempted.
- Cardiac and/or respiratory arrest occurs during or after:
    - Sedative or analgesic administration.
    - Pharmacologically Assisted Intubations (PAI)
    - Synchronized cardioversion.
    - Physical or chemical restraint

Investigation

The investigation of a Clinical Inquiry is performed. The following items may be reviewed (as available) in the course of the investigation:

- Review of the initial concern or questions
- Review of the patient care record
- Review of the computer aided dispatch (CAD) record
- Interview with the crew involved
- Interview with other responders, bystanders, patient/family or hospital staff
- Hospital reports or autopsy results
- Any other relevant information source

Determination of Magnitude

Action or care appears appropriate or minor deviation from acceptable.

If it is determined, after review of the issue by the Agency Officer that the Provider's actions were appropriate or a minor deviation occurred, appropriate feedback will be delivered and documented accordingly.

Action or care appears to deviate significantly from expectations

If the outcome of the review reveals a Provider has deficiencies in an area, an Education Plan may be created in consultation with the Medical Director to assure the deficient areas are appropriately addressed.

- When development of an Education Plan is appropriate the Agency EMS Officer/Coordinator will develop and administer the plan.

If a Provider fails to participate in or is unsuccessful in the Education Plan, the individual may be Decredentialed, or level of Credentials changed. These outcomes are severe and only necessary if the Provider refuses to participate in re-education or repeated attempts to assist the Provider in overcoming deficiencies have proven unsuccessful.

Peer Review Process

The Peer Review Process is a tool used to look at clinical issues in a fair and objective way. Peers from each agency involved will participate in the review of an incident. Peer Review may be initiated to better understand the complexities of an incident. The following criteria apply to peer selection:

- No less than two personnel with similar Credentials and tenure to give the perspective of someone with similar experience and training.
- At least one other experienced Provider to provide the system's medical expectations perspective.

Peer reviews **may** be conducted in any or all of the following situations at the discretion of the Agency EMS Officer/Coordinator:

- An incident with multi-agency involvement where it may be useful to get all parties together in order to discuss the incident

- A Provider specifically requests a peer review
- Incidents of significant or unusual magnitude

Peer review **will** be conducted when any of the five (5) potential Decredentialing issues has been identified:

1. **Falsification of Patient Care Documentation:** The Provider intentionally provided false information on a patient care record
2. **Intentional Harm to a Patient:** A Provider deliberately harmed a patient
3. **Intentionally Withholding Care From a Patient:** A Provider intentionally withholds appropriate care from a patient
4. **Providing Care Under the Influence of Drugs or Alcohol:** A Provider performs care under the influence of any illicit substance
5. **Failure to Remediate:** A Provider either refuses to or is unsuccessful in a re-education process.

Possible outcome of a peer review

Appropriate feedback
Development of a formal Education Plan
Referral to non-clinical, agency specific processes
Suspension or revocation of Credentials to practice

Closure of Inquiry

Once all documentation and feedback is delivered, and all requirements (if any) are met, the issue will be closed and kept in a permanent and confidential file.

What is the Definition of a "Patient"?

With the advent of cell phones and the increased number of requests for emergency medical care by individuals other than patients themselves (for example, a passer-by that calls 9-1-1 for a motor vehicle crash where there are no injuries, complaints or indication of injury, and EMS is dispatched to the scene), it is necessary to define a patient in our System. Why? Because anyone that fits the definition of a patient must be properly evaluated and/or appropriate treatment options taken (including an informed refusal if the competent patient absolutely does not wish medical care or transport despite our suggestions that they do). Similarly, anyone that does not fit the definition of a patient as defined by our System does not require an evaluation or completion of a Patient Care Record. If there is ever any doubt, an individual should be deemed a patient and appropriate evaluation should take place.

It is important to remember that the definition of a patient requires the input of both the individual and the Provider, and an assessment of the circumstances

that led to the 9-1-1 call. The definition of a patient is a separate question from whether or not the patient gets evaluated or treated.

The definition of a patient is any human being that:

- Has a complaint suggestive of potential illness or injury
- Requests evaluation for potential illness or injury
- Has obvious evidence of illness or injury
- Has experienced an acute event that could reasonably lead to illness or injury
- Is in a circumstance or situation that could reasonably lead to illness or injury

All individuals meeting any of the above criteria are considered “patients” in the System. These criteria are intended to be considered in the widest sense. If there are any questions or doubts, the individual should be considered a patient.

Patient Consent and Refusal

The United States Supreme Court has recognized that a “person has a constitutionally protected liberty interest in refusing unwanted medical treatment” even if refusal could result in death. Although courts protect a patient’s rights to refuse care, “preservation of life, prevention of suicide, maintenance of the ethical integrity of the medical profession, and protection of innocent third parties” may also be considered when evaluating a patient’s wish to refuse treatment. Each case must be examined individually.

In providing medical care, the universal goal is to act in the best interest of the patient. This goal is based on the principle of autonomy, which allows patients to decide what is best for them. A patient’s best interest may be served by providing leading-edge medical treatment, or it may be served simply by honoring a patient’s refusal of care. Although complicated issues can arise when Providers and patients disagree, the best policy is to provide adequate information to the patient, allow time for ample discussion, and document the medical record meticulously.

With certain exceptions (see Implied Consent), all adult patients, and select minor patients, have a right to consent to medical evaluation and/or treatment, or to refuse medical evaluation and/or treatment if they have the legal competency and present mental capacity to do so. There are three specific forms of consent that apply to EMS: Informed Consent, Implied Consent, and Substituted Consent.

Informed Consent

Informed consent is more than legality. It is a moral responsibility on the part of the Provider, based in the recognition of individual autonomy, dignity, and the present mental capacity for self-determination. With informed consent, the patient is aware of, and understands, the risk(s) of any care provided, procedures

performed, medications administered, and the consequences of refusing treatment and/or transport. They should also be aware of the options available to them if they choose not to accept our evaluation and/or treatment.

Implied Consent

In potentially life-threatening emergency situations, consent for treatment is not required. The law presumes that if the individual with a real or potential life-threatening injury or illness were conscious and able to communicate, he/she would consent to emergency treatment. In life-threatening emergency situations, consent for emergency care is not required if the individual is:

- Unable to communicate because of an injury, accident, illness, or unconsciousness and suffering from what reasonably appears to be a life-threatening injury or illness
  OR
- Suffering from impaired present mental capacity
  OR
- A minor who is suffering from what appears to be a life-threatening injury or illness and whose parents, managing or possessory conservator, or guardian is not present

Substituted Consent

This is the situation in which another person consents for the patient, as in minors, incapacitated patients, incarcerated patients, and those determined by courts to be legally incompetent. The fundamental issue in informed, substituted consent for minors is a question of how decisions should be made for those who are not fully competent to decide for themselves. Parents or guardians are entitled to provide permission because they have the legal responsibility, and in the absence of abuse or neglect, are assumed to act in the best interests of the child. However, there is a moral and ethical “need to respect the rights and autonomy of every individual, regardless of age.” Providers must walk a fine line between respect for minors’ autonomy, respect for parental rights, and the law. The whole issue of when a patient may or may not be considered legally competent and possessing the present mental capacity to consent to, or refuse care, is complex and confusing in the emergency care environment. It is our obligation to make sure we address each of the following principles:

- When they can, patients must give us permission to evaluate and/or treat them for any presumed or real medical condition.
- We must evaluate and/or treat those patients who are unable to make a decision due to their illness, injury or circumstances.
- We must be able to determine whether a patient has the legal competency and present mental capacity to refuse evaluation and/or treatment.
- We must inform the patient of the risks and potential alternatives to refusing or accepting care and be reasonably certain they understand.

- We must honor a patient's refusal of evaluation and/or treatment if they have the legal competency and present mental capacity to refuse that evaluation and/or treatment.

Any person, eighteen (18) years of age or older, that is deemed to have the legal competency and present mental capacity to consent, may consent to, or **refuse** evaluation, treatment, and/or transportation. That person may also sign a legal document (Patient Refusal Form).

If the patient has the legal competency and present mental capacity to consent, and chooses to refuse further evaluation and/or treatment, the Provider must, after assessing the patient's ability to understand, provide the patient with information regarding the risks of refusal, the alternative options available, and what to do if conditions persist or worsen.

A Provider may be denied access to personal property (land and home) by the property owner or patient, *if there is no obvious immediate life threat to a patient*.

Legal Competency and Present Mental Capacity to Consent or Refuse Evaluation or Treatment

It is our obligation to offer evaluation and/or treatment to *anyone* with evidence of illness or injury regardless of whether they initially choose to refuse that evaluation and/or treatment. However, a patient must have the legal competency and present mental capacity to consent before consent is deemed to be valid.

- **Mental competency:** legal term, and there is a presumption of legal mental competency unless one has been declared mentally incompetent by a court of law. Legally competent individuals have a right to refuse medical treatment.
- **Present mental capacity:** refers to one's present mental ability to understand and appreciate the nature and consequences of his/her condition and to make rational treatment decisions.

While there is criteria for legal competency and present mental capacity as defined below, there is no way to cover every potential circumstance with a written guideline. Thus, we should always determine a patient disposition that is safe and appropriate given the circumstances

- 18 years of age or older
- Alert, able to communicate, and demonstrates appropriate cognitive skills for the circumstances of the situation
- Showing no indication of impairment by alcohol or drug use
- Showing no current evidence of suicidal ideations, suicide attempts or any indication that they may be a danger to themselves or others. Law enforcement must be requested for this patient population.
- Showing no current evidence of bizarre/psychotic thoughts and/or behavior, or displaying behavior that is inconsistent with the circumstances of the situation
- No physical finding or evidence of illness or injury that may impair their ability to understand and evaluate their current situation (for example, a patient with a head injury and an abnormal GCS, a patient with significant hypoxia or hypotension, etc)

- A patient that has NOT been declared legally incompetent by a court of law.
    - If a patient has been declared legally incompetent, his/her court appointed guardian has the right to consent to, or refuse, evaluation, treatment, and/or transportation for the patient.

When evaluating a patient for the ability to consent to or refuse treatment, the Provider must determine whether or not the patient possesses the present mental capacity to understand and appreciate the nature and consequences of his/her condition and to make rational treatment decisions. Such an evaluation must take into consideration not only the patient's orientation to person, place, time, and event, but also their memory function, their ability to engage in associative and abstract thinking about their condition, their ability to respond rationally to questions, and their ability to apply information given to them by the Providers. A thorough test of the patient's mental status is one that assesses *orientation, registration (memory), attention, calculation, recall and languag*e. This can be accomplished fairly rapidly. For example

- **Level of Consciousness (AVPU)-** The use of appropriate "noxious stimuli" is an acceptable practice in our System to assist in determining a patient's level of consciousness. This may be in the form of ammonia inhalants or painful stimuli through the application of pressure to the fingernail bed.
- **Awake, alert, and oriente**d- elicit specific/detailed responses when questioning your patient to determine A and A and O status
- **Registration**- give your patient the name of 3 unrelated items (dog, pencil, ball) and ask them to repeat them and remember them because you will ask again later
- **Attention and calculatio**n- ask the patient to spell a five-letter word backwards (pound, earth, space, ready, daily, etc.), or count backward from 100 subtracting 7's.
- **Recal**l- ask the patient to recall the 3 items identified in "registration."
- **Languag**e- state a simple phrase ("no if, ands, or buts") and ask the patient to repeat. Also test the patient's ability to respond to verbal commands by asking the patient to do something with an object ("hold this piece of paper", "fold this paper in half") or identify two objects held up such as a watch or pencil.

Patients with impaired present mental capacity may be treated under *implied consen*t.

If patient does not have present mental capacity but continues to refuse treatement or is combative, law enforcement must be dispatched to the scene and participate in the evaluation and decision process. OLMC should be contacted as an additional resource. Obviously, if in the opinion of the ALS Credentialed Provider in charge, there is an *immediate* risk to life or significant morbidity, patient safety and care are the priority *(implied consent* would apply here).

Finally, the Provider's findings must be documented with facts, not conclusions, and such documentation must be sufficient to demonstrate the patient's mental

status and understanding of his/her condition and the consequences of refusing treatment.

Consent to Evaluation/Treatment for a Minor and Refusal of Evaluation/Treatment for a Minor

The following person(s) may consent to, or refuse, the evaluation, treatment, and/or transportation of a minor:

- Parent
- Grandparent
- Adult (> 18) brother or sister
- Adult (> 18) aunt or uncle
- Educational institution in which the child is enrolled that has received written authorization to consent/refuse from a person having the right to consent/refuse.
- Adult who has actual care, control, and possession of the child *and/or* has written authorization to consent/refuse from a person having the right to consent/refuse (i.e., daycare camps, soccer moms, carpools, etc.)
- Adult who has actual care, control, and possession of a child under the jurisdiction of a juvenile court
- A court having jurisdiction over a suit affecting the parent-child relationship of which the child is the subject
- A peace officer who has lawfully taken custody of minor, if the peace officer has reasonable grounds to believe the minor is in need of immediate medical treatment.
- A managing or possessory conservator or guardian.

A Provider may be denied access to minor children by a parent or guardian if there is no obvious immediate life threat to the patient. However, in general, parents or guardians cannot refuse life-saving therapy for a child based on religious or other grounds.

When treating minors, it is important that there be an interactive process between them and the Provider. The interaction should involve developmentally appropriate disclosure about the illness/injury, the solicitation of the minor's willingness and preferences regarding treatment, and decision options. Although the intent of this interaction is to involve the child in decisions, the way in which the participation is framed is important. As with any patient, minors should be treated with respect.

Initiation and Termination of Cardiopulmonary Resuscitation (CPR)

Initiation of Cardiopulmonary Resuscitation (CPR)

Initiation of Cardiopulmonary Resuscitation (CPR) by any credentialed Provider is not indicated for pulseless,apneic patients in the presence of:

- Obvious appearance of death

- Decomposition
- Obvious dependent lividity
- Rigor mortis
- Asystole on monitor with unknown down time.
- Obvious mortal wounds (massive burn injuries, severe traumatic injuries with obvious signs of organ destruction such as brain, thoracic contents, etc.)
    - Severe extremity damage, including amputation, should not be considered an obvious mortal wound without coexistent injury/illness
- Patient submersion of greater than 60 minutes from arrival of the first Public Safety entity until the patient is in a position for resuscitative efforts to be initiated. Exceptions include extreme cold water submersions.
    - Operationally, on-scene rescuers should consider conversion from rescue to recovery at 60 minutes. Exceptions to this guideline include any potential for a viable patient such as a diver with an air source or a patient trapped with a potential air source. Final decision for transition from rescue to recovery mode rests with on-scene command.
- Idaho POST or Comfort One order/Out of State DNR
    - Valid Out-Of-Hospital Do Not Resuscitate Written Order or Device from any (US) State
    - In nursing home or assisted living, a facility DNR form or signed order for DNR.
    - A valid licensed physician on scene or by telephone orders no resuscitation efforts

In addition, unless a patient arrests *during* transport, Credentialed Providers should not transport or continue Cardiopulmonary Resuscitation (CPR) for pulseless, apneic patients suffering from blunt or penetrating trauma that do not respond following intubation, IV fluids and bilateral needle decompression, if available and indicated.

Termination of Resuscitation Efforts Without OLMC

Any System Credentialed Provider, in the following circumstances, may discontinue resuscitation efforts without OLMC:

- Resuscitation efforts were inappropriately initiated when criteria to not resuscitate were present
- A valid advanced directive/DNR was discovered after resuscitative efforts have been initiated

When a Credentialed Provider makes the decision to not initiate resuscitative efforts, or to terminate efforts, the following procedures should be followed by the Provider(s) making that decision:

- Contact Agency Dispatch, by radio or telephone and request a time of death (This must be on a recorded line.)

- Cancel additional BLS units, downgrade ALS to Code 1
- Document per System and agency guidelines
- Coordinate with law enforcement/coroner for body disposition

Termination of Resuscitation Efforts Utilizing OLMC

Except for the previous criteria, OLMC should be contacted any time resuscitation efforts have been initiated and termination of resuscitation efforts is being considered. Typically after 20 minutes of ongoing resuscitation attempts without Return of Spontaneous Circulation (ROSC) and no shocks indicated by AED/Monitor and/or ETCO2 < 20, termination of efforts should be considered.

- If at anytime during resuscitation attempts, ROSC is achieved, the 20 minute timeline should be restarted.

The following cases may require transport to hospital after consultation with OLMC:

- Hypothermia
- Persistent ventricular fibrillation/ventricular tachycardia
- Persistent PEA with an electrical heart rate greater than 40
- For the intubated patient, ETCO2 >20 mmHg

When OLMC is involved in the decision to terminate resuscitative efforts, the following procedures should be implemented:

- Resuscitative efforts must be continued while requesting a pronouncement.
- Contact OLMC at Portneuf Medical Center or designated hospital via phone or radio.
- Document per System and agency protocols

Out of Hospital Advanced Directives Pertaining to Resuscitation

Patients have a legal right to consent to, or refuse, recommended medical procedures, including resuscitative efforts. These patients require thoughtful consideration at critical times. The decision to honor, or not to honor, an Out of Hospital Do Not Resuscitate (POST/Comfort One/Medical Facility DNR) must be made quickly and accurately. Remember, it is our obligation to carry out the patient's appropriately designated medical choices, even when they can't direct us in cases of cardiopulmonary arrest.
An OOH DNR order should NOT be honored and resuscitative efforts should be initiated in the following circumstances:

- The patient or person who executed the order destroys the form and/or removes the identification device
  OR
- The patient or person who executed the order directs someone in their presence to destroy the form and/or removes the identification device
  OR

- The patient or person who executed the order tells the EMS Providers or attending physician that it is his/her intent to revoke the order
  OR
- The attending Physician or physician's designee, if present at the time of revocation, has recorded in the patient's medical record the time, date, and place of the revocation and enters *"VOID"* on each page of the DNR order

In the event that there is a question as whether to honor or not honor an OOH DNR, contact OLMC as needed.

Important Points to Remember

- It is appropriate to transport patients who have arrested to the hospital for pronouncement if, in the assessment of the transport Providers, circumstances mandate such an action (for example, death in a public place).
- Always rule out a non-traumatic etiology for what may be perceived as a traumatic arrest (for example, primary Ventricular Fibrillation resulting in a minor car crash).
- Anytime a DNR is not honored, the reason must be documented in the Patient Care Record (PCR).
- An Advanced Directive does not imply that a patient refuses palliative and/or supportive care. Care intended for the comfort of the patient should not be withheld based on an Medical Power of Attorney..
- When in doubt, always initiate resuscitative efforts. Later termination can be implemented if appropriate.
- Refer to the POST/Comfort One/DNR Guideline.

Provision of Care While Off-Duty

In order to benefit patients and utilize all available resources in the system, when a Credentialed Provider finds the need to provide care while off-duty, the following procedure will be followed:

- The Credentialed Provider will identify himself/herself and the level of credentialing
- Level of care provided will not exceed the system scope of practice for the credentialed provider
- System Treatment Guidelines will be followed
- If a credentialed provider performs an intervention that is above the licensure of the transporting agency, the credentialed provider will need to maintain care of the patient until transfer to a higher or equal provider. For example, a paramedic who intubates a patient, but the transport agency is only a basic life support agency, will have to remain with the patient until arrival at hospital or transfer to paramedic unit or air medical agency.

- Any intervention by the off-duty personnel needs to be documented on the PCR.
- If outside the geographic boundaries of the System Medical Direction (outside Bannock County, Power County or Fort Hall), and an advanced intervention is performed (intubation, needle decompression, needle or surgical cricothyrotomy), the Medical Director must be notified immediately upon completion of patient care.

Physician On-Scene

EMS personnel work under the direction of the Medical Director through written treatment guidelines and receive direct medical direction from the medical control physician. There will be times though that a physician will be on-scene and wish to provide or direct patient care. During these situations, the following will be followed:

Medical Director/Medical Director Designee

- When the medical director or his designee is on scene, he can choose to provide direct medical direction at his discretion

When a licensed Idaho physician is on location and requests a deviation from the treatment guidelines, the physician must accept responsibility for patient care including attending the patient during transport. While the credentialed provider may assist the physician in procedures, the provider shall not exceed their scope of practice.

In the event of a licensed Idaho physician is on location but will not accept responsibility for patient care, **or** a licensed Idaho physician is directing patient care by telephone and a request for a deviation from treatment guidelines, the following shall apply:

- The Physician must be a Idaho licensed M.D. or D.O. with proper identification or personally known to the provider.
- Personnel shall request that the private physician call the on-line medical control physician for consultation.
- Personnel will then establish contact with medical control physician to confirm orders.

Simplot physician assistant is authorized to provide direction to SERV-1.

Deployment, Dispatch, and Modification of Response

Each agency will develop a deployment and response plan that is consistent and will best utilize the resources available to the system. Response performance parameters should be established and reviewed on an on-going basis. Automatic mutual aid agreements should be in place

Dispatch performance should be monitored and comply with established MPD and NFPA criteria. Caller interrogation and pre-arrival instructions should not delay dispatch of the units. Additional information as deemed relevant can be relayed to units after units are enroute.
Dispatch of resources should be limited to the following components:

- Agency/Unit
- Nature of Call (fall, SOB, CP, Abd. Pain, Injury, MCC, etc.)
- Address of incident
- Common name of address
- Jurisdiction

The closest appropriate unit should be dispatched at all times regardless of district or zone
Calls should be prioritized with non-emergency calls delayed as needed
Initial deployment and any change in deployment of agency resources must be approved by the Medical Director
Once a unit has been dispatched to a call, it may only cancel or modify its response during the following situations:

- Assessment of credentialed provider on scene determines there is no need for additional resources
- Because of the long distances to respond and for the safety of responding units, police officers who are on scene and obtain information from the patient that they do not wish EMS evaluation can cancel EMS.
- An ALS unit while responding to a BLS call or non-emergency call can be diverted if an ALS call is received and there is no ALS unit available or they are the closest unit. A second unit must then be dispatched to the original call immediately. Determination of BLS/ALS will be through Medical Priority Dispatching.

Transport Destination

Except for non-emergency transfers, all patients should be transported to the most appropriate acute care hospital consistent with the patient condition and need for medical intervention.
Transport to clinics or private doctors' offices will be determined on a case-by-case basis with OLMC and the respective clinic. (SERV-1 has approval to transport to Simplot Clinic and Fort Hall to the IHS Clinic).
Patient and private physician preference will be honored for transport to Portneuf Medical Center, Harms Hospital, Bingham Memorial Hospital, Oneida County Hospital, and Franklin County Hospital as long as the hospital is the closest appropriate hospital.
During disaster situation, transport destination will be decided by the incident commander or designee and may included urgent care and clinics that participate in the disaster plan.

Disaster/Multi-Patient/Mass Casualty

Incidents that overwhelm the resources of the system pose a particularly difficult challenge. Planning for such incidents should be formalized and drilled regularly. During these situations, the following will apply:

- Credentialed personnel will follow system guidelines and not exceed the respective scope of practice
- NIMS and ICS principles will be followed
- Triage using the START method will be utilized
- Documentation of care provided is still required however a triage tag will serve as appropriate documentation as long as it includes patient identification and interventions
- The regional triage tag will be utilized – currently that is the START triage tag
- Any requirement for OLMC will be suspended for treatment guidelines that require OLMC prior to intervention. OLMC should still be established at the first available opportunity.
- During air-borne infectious pandemic, scope of practice will be consistent with the EMS Physician Commission Scope of Practice for Airborne Pathogen Pandemic.

Introduction of New Equipment or Technology

Technology in EMS changes each year and new devices and equipment becomes available. Some have minimal research showing benefit, while others are merely substitutions for an existing item. If new technology or equipment is introduced into the system, the following will apply:

- All technology or equipment changes must be approved by the medical director
- All items must be within the scope of practice of the provider.
- Item will be reviewed for clinical and cost-effectiveness.
- Standardized training will be developed including objectives, education content, and evaluation tool to ensure competency.
- Each Credentialed provider will receive standardized training and show competency.
- New item may be added to periodic skill review at the discretion of the medical director.

Safe Haven Act

The Idaho *Safe Haven* Act is intended to provide a safe alternative for parents who otherwise might abandon their infant. A safe haven is authorized by law to accept a baby less than 30 days of age, directly from a parent, without identifying the parent. The parent is not required to provide any information to the safe

haven, but may volunteer medical or other information. The parent remains anonymous and will not be prosecuted for child neglect or abandonment.

Emergency medical personnel may respond to a 911 call requesting *Safe Haven* or be presented with an **infant under 30 days old** at a Transport or Non-Transport EMS agency.

When contacted by a custodial parent with a request for *Safe Haven*, proceed with the following steps:

- Determine if parent is requesting *Safe Haven* and expresses an intent not to reclaim the child.
- Provide aid to protect and preserve the physical health and safety of the child.
- If law enforcement is not enroute or present at scene, notify dispatch to send law enforcement to place child in protective custody.
- Do not ask for identity of the parent and, if known, keep confidential.
- Accept voluntary information given by the parent regarding the health history of the parent or the child.
- Transport child to hospital in a child safety seat.
- Report any voluntary information to the hospital personnel while keeping the identity of parent and child confidential, if known.
- Record encounter on *Patient Care Report* or run report and document type of call as “Other” with *Safe Haven* listed on the line below “Other”.